Q Generic Confounders

Record ID

_____

Questionnaire - Metadata

Session ID

_____

Questionnaire Started At

_____

Questionnaire Completed At

_____

Questionnaire Duration (seconds)

_____

SMOKING

Have you been a regular smoker or not within the last 3 years?

- ◯ Yes
- ◯ No

Have you ever smoked regularly (more than a few times a month for at least two months)?
This includes tobacco, cannabis, vapes, e-cigarettes, hookah, or pipes.

- ◯ I've never smoked regularly
- ◯ I used to smoke
- ◯ I currently smoke
- ◯ Prefer not to answer

At what age did you start smoking?

_____

At what age did you stop?

_____

Please select smoking types used (Check all that apply)

- ☐ Tobacco cigarettes
- ☐ Cannabis joints, bong, pipe
- ☐ Vapes
- ☐ e-cigarettes
- ☐ Hookah
- ☐ Pipes
- ☐ Other (Please specify)
- ☐ Prefer not to answer

If you selected "other" for smoking type, please specify:

_____

How often do/did you smoke?

- ◯ Multiple times a day
- ◯ About once a day
- ◯ A few times a week
- ◯ A few times a month
- ◯ A few times a year
- ◯ Prefer not to answer

ALCOHOL CONSUMPTION

Do you drink alcohol?
- ◯ Yes
- ◯ No
- ◯ Prefer not to answer

How often do you have at least one drink containing alcohol?
Drinks can be beer, wine, shots of liquor, cocktails containing a shot of liquor
- ◯ Monthly or less
- ◯ 2 - 4 times a month
- ◯ 2 - 3 times a week
- ◯ 4 or more times a week
- ◯ Prefer not to answer

How many drinks containing alcohol do you have on a typical day when you are drinking?
One drink is 12 oz. beer, 5 oz. wine, 1.5 oz. (one shot) liquor
- ◯ 0 - 2
- ◯ 3 - 4
- ◯ 5 - 6
- ◯ 7 - 9
- ◯ 10 or more
- ◯ Prefer not to answer

How often did you have six or more drinks on one occasion in the past year?
- ◯ Never in the past year
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily
- ◯ Prefer not to answer

Have you drunk alcohol today?
- ◯ Yes
- ◯ No

How many drinks did you have?

_____

Have you ever been in rehab or counseling for heavy alcohol use?
- ◯ Never in the past year
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily
- ◯ Prefer not to answer

Are you currently in recovery for alcohol use?
- ◯ Yes
- ◯ No

SUBSTANCE USE

How many times in the past YEAR have you used a recreational substance or medication for reasons or in doses other than prescribed?

Recreational substances include methamphetamines (speed, crystal), cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).

More than one
- ◯ Yes
- ◯ No

Are you currently in recovery for substance use?
- ◯ Yes
- ◯ No

During the past TWO (2) WEEKS, about how often did you use any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed?

	Not at all	One or two days	Several days	More than half the days	Nearly every day
Painkillers (like Vicodin)	◯	◯	◯	◯	◯
Stimulants (like Ritalin, Adderall)	◯	◯	◯	◯	◯
Sedatives or tranquilizers (like sleeping pills or Valium)	◯	◯	◯	◯	◯
Marijuana	◯	◯	◯	◯	◯
Cocaine or crack	◯	◯	◯	◯	◯
Club drugs (like ecstasy)	◯	◯	◯	◯	◯
Hallucinogens (like LSD)	◯	◯	◯	◯	◯
Heroin or other opioids, including synthetic opioids like fentanyl	◯	◯	◯	◯	◯
Inhalants or solvents (like glue)	◯	◯	◯	◯	◯
Methamphetamine (like speed)	◯	◯	◯	◯	◯

CAFFEINE INTAKE

How many small (8oz or 230ml) cups of coffee OR shots of espresso OR caffeinated teas do you drink on a typical day? _____

How many small (8oz or 230ml) cups of coffee OR shots of espresso OR caffeinated teas have you had TODAY? _____

HYDRATION

How many small (8oz or 230ml) cups of water do you drink on a typical day? _____

How many small (8oz or 230ml) cups of water have you had TODAY? _____

DENTAL PROBLEMS

Do you have any dental problems that might affect speech?
◯ Yes
◯ No

Do you currently have any tooth loss, dentures, retainers or braces? (Please specify) _____

ALLERGIES OR COLD SYMPTOMS

Do you currently have seasonal allergies, cold-like symptoms or other conditions that may affect your voice today?

- ◯ Yes
- ◯ No

Check all that apply:

- ☐ Nasal congestion or obstruction
- ☐ Cough
- ☐ Scratchy or sore throat
- ☐ Shortness of breath

TIREDNESS

How tired are you?
0=not tired at all, 10=extremely tired

◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

HEIGHT AND WEIGHT

Height (inches)

_____
(inches)

Weight (pounds)

_____
(lbs)

Unit

- ◯ Metric
- ◯ US customary units

SYMPTOMS

There are some symptoms that can affect your voice. Are you currently experiencing any of these symptoms? Check all that apply.

- ☐ Anxiety or nervousness
- ☐ Confusion
- ☐ Dizziness
- ☐ Frequent or severe headache or migraine
- ☐ Sleep disturbance
- ☐ Speech difficulty
- ☐ Prefer not to answer

EAR, NOSE, THROAT MEDICAL HISTORY

Do you have any of these voice, communication, or hearing conditions? (check all that apply)

Ear

- ☐ Chronic ear infection
- ☐ Cochlear implant
- ☐ Hearing loss

Nose

- ☐ Frequent sinusitis

Throat	☐ Pre-cancerous throat lesion (e.g. laryngeal leukoplakia or keratosis ☐ Reflux (heartburn) ☐ Reinke's edema, polypoid corditis, or smoker's larynx ☐ Sjögren's syndrome ☐ Swallowing disorders (dysphagia) ☐ Throat cancer ☐ Thyroid disease ☐ Velopharyngeal insufficiency ☐ Vocal fold dysfunction, paradoxical vocal fold motion, or inducible laryngeal obstruction ☐ Vocal fold polyp, nodule, or cyst ☐ Vocal hemorrhage or bleed ☐ Voice/throat disorder
Head	☐ Radiation around head and neck ☐ Seasonal allergies

Have you had any of the interventions mentioned below? (check all that apply)

Ear	☐ Chronic ear surgery (e.g. mastoid) ☐ Ear tubes
Nose	☐ Septoplasty/Rhinoplasty ☐ Sinus surgery
Throat	☐ Airway surgery ☐ Throat surgery ☐ Thyroid surgery ☐ Tonsillectomy/Adenoidectomy
Head	☐ Head/Neck cancer (e.g. oropharyngeal cancer) ☐ Sleep surgery

NEUROLOGICAL MEDICAL HISTORY

Have you been diagnosed with any of these neurological health conditions by a clinician? (check all that apply)

Neurological Medical History	☐ Brain tumor ☐ Dysarthria ☐ Epilepsy ☐ Multiple sclerosis ☐ Traumatic brain injury ☐ Other
Do you currently have these conditions or currently experience symptoms as a result of having had these conditions?	◯ None ◯ Only some ◯ All
Which ones do you currently have? (please specify)	_____

RESPIRATORY CONDITIONS

Respiratory Conditions	☐ Bronchiectasis ☐ Cancer (lung or metastatic) ☐ Emphysema ☐ Interstitial lung disease (sarcoidosis, pulmonary fibrosis) ☐ Pneumothorax or atelectasis (collapsed lung) ☐ Pulmonary hypertension ☐ Radiation to the chest ☐ Tuberculosis
Cancer (lung or metastatic)	☐ Lung ☐ Metastatic
Have you had COVID recently, or are you currently experiencing the effects of long COVID? (check all that apply)	☐ COVID in the past year ☐ Long COVID (symptoms persisted at least four weeks after initial infection)
Have you had COVID in the past month?	◯ Yes ◯ No
Are you currently using CPAP or supplemental oxygen? (check all that apply)	☐ Active CPAP use ☐ On supplemental oxygen
Have you had any of the interventions mentioned below? (check all that apply) Respiratory medical history	☐ Craniofacial or chest wall trauma ☐ Previous lobectomy ☐ Prior chest/airway surgery ☐ Prolonged intubation (more than a week)
Have you been exposed to environmental pollution that may affect your breathing or voice?	◯ Yes ◯ No
Are you having difficulty breathing today?	◯ Yes ◯ No
Please specify the level of difficulty	◯ Slight Difficulty ◯ Moderate Difficulty ◯ Significant Difficulty
Are you coughing today?	◯ Yes ◯ No
What is the severity of your cough? A selection of 10 being means the most severe.	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10

CIRCULATORY AND OTHER CONDITIONS

Have you been diagnosed with any of these circulatory or heart conditions by a clinician? (check all that apply)

- ☐ Atrial fibrillation
- ☐ Cardiac condition
- ☐ Chronic pericarditis
- ☐ Congestive heart failure
- ☐ Coronary heart disease
- ☐ Hypertension

Cardiac condition

_____

Some other conditions can affect the sound of your voice. Have you been diagnosed with any of these conditions by a clinician? (check all that apply)

- ☐ Chronic kidney disease
- ☐ Diabetes
- ☐ Infectious disease
- ☐ Obesity
- ☐ Scoliosis

Infectious disease

_____

PHYSICAL HEALTH

In the past 30 days, how much difficulty did you have in:

	None	Mild	Moderate	Severe	Extreme or cannot do
Standing for long periods such as 30 minutes?	○	○	○	○	○
Taking care of your household responsibilities?	○	○	○	○	○
Learning a new task, for example, learning how to get to a new place?	○	○	○	○	○
How much of a problem did you have joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?	○	○	○	○	○
How much have you been emotionally affected by your health problems?	○	○	○	○	○
Concentrating on doing something for ten minutes?	○	○	○	○	○
Walking a long distance such as a kilometre [or equivalent]?	○	○	○	○	○
Washing your whole body?	○	○	○	○	○

Getting dressed?	○	○	○	○	○
Dealing with people you do not know?	○	○	○	○	○
Maintaining a friendship?	○	○	○	○	○
Your day-to-day work?	○	○	○	○	○

Overall, in the past 30 days, how many days were these difficulties present?

_____ (days)

In the past 30 days, for how many days were you totally unable to carry out your usual activities or work because of any health condition?

_____ (days)

In the past 30 days, not counting the days that you were totally unable, for how many days did you cut back or reduce your usual activities or work because of any health condition?

_____ (days)

MEDICATIONS

Do you currently take or use any of these medications or substances? (Check all that apply)

- ☐ Antibiotics
- ☐ Anti-histamines (allergy medications)
- ☐ Anti-Hypertensive Medications (Blood Pressure Medication)
- ☐ Diuretics (ex: Lasix)
- ☐ Decongestants
- ☐ Muscle relaxants (ex: Baclofen)
- ☐ Hormone use
- ☐ Inhaled corticosteroids
- ☐ Oral steroids
- ☐ Anti-anxiety medications: (ex: Benzodiazepine)
- ☐ Chronic Pain medication
- ☐ Psychotropic/antipsychotic medications (ex: Clozapine)
- ☐ Antidepressants (ex: amitryptiline)
- ☐ Immune suppressors (ex: Methotrexate)
- ☐ Reflux medications (ex: Pantoprazole, Nexium)
- ☐ Anticholinergics (ex: Ventolin)
- ☐ Anticoagulants (blood thinners)
- ☐ Antiepileptic (ex: Phenytoin)

Hormone use

- ☐ Oral contraceptive
- ☐ Hormonal replacement therapy (HRT)
- ☐ Androgenic steroids
- ☐ Other

Chronic Pain medication

- ☐ NSAIDs (ex: Ibuprofen/Advil/Cerebrex)
- ☐ Morphine/Oxycodone
- ☐ Neuro-modulators (ex: Gabapentin, Lyrica)

GYNECOLOGICAL

Do you menstruate?

- ◯ Does not apply
- ◯ Yes
- ◯ No
- ◯ Prefer no to answer

Please explain

- ◯ I am pregnant
- ◯ I have an IUD
- ◯ I have gone through menopause
- ◯ Other

If you selected "other" for menstruate, please specify:

_____

Where in your cycle are you?
(We ask because this may affect your voice.)

- ◯ Menstruating
- ◯ Premenstrual
- ◯ Postmenstrual
- ◯ Prefer not to answer

VOICE ACTIVITY

Do you do one of these jobs or hobbies that requires using your voice for many hours a day? (check all that apply)

- ☐ Bartender
- ☐ Waiter, receptionist
- ☐ Speaking (secretary, call center, attorney, salesperson)
- ☐ Teacher
- ☐ Singer
- ☐ Cheerleading
- ☐ Other

If you selected "other" for voice activity, please specify:

_____

How many hours per day do you do this activity with a loud voice or in a loud environment that requires elevating your voice (for instance, a noisy bar or a noisy classroom)?

_____
(hours)

READING ACTIVITY

"How good do you think you are at reading out loud in [English/Spanish/French], that is reading out loud without making mistakes and understanding what you read at a normal rate?"

- ◯ Excellent
- ◯ Very good
- ◯ Good
- ◯ Fair
- ◯ Poor